NORTH CAROLINA DIVISION OF AGING AND ADULT SERVICES
and
_____ AREA AGENCY ON AGING

MONITORING TOOL FOR HOME HEALTH SERVICES

Community Service Provider: _____
Review Date: _____ State Fiscal Year _____
Interviewer: _____
Person(s) Interviewed and Title: _____

****

PROGRAM ADMINISTRATION

Provisions of the Standard

1. All Home Health services provided are prescribed by a physician. (Nursing, Physical, Speech and Occupational Therapy, Medical Social Services, and Nutrition Care) Yes__ No__
(Page 2 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

2. Skilled services provided include at least one of the following:

a. Nursing (RN, LPN) Yes__ No__
b. Physical Therapy Yes__ No__
c. Speech Therapy Yes__ No__
d. Occupational Therapy Yes__ No__
e. Medical Social Services Yes__ No__
f. Nutrition Care Services Yes__ No__
(Pages 2,3,4 & 5 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

3. Nursing Services are provided by a Registered Nurse with a current NC license or a Licensed Practical Nurse with a current NC license who is supervised by a Registered Nurse. Yes__ No__
(Page 2 - Home Health Services Standard)

Documentation verifying compliance: _____
_____

Comments: _____
_____

4. Nursing Services are provided in accordance with the North Carolina Nursing Practice Act - Article 9A of G.S. 90-171.20(7)(8). {Attached are copies of the **Components of Nursing Practice for the Registered Nurse and the Licensed Practical Nurse** (NCAC 21 Chapter 36)} Yes__ No__
(Pages 2 & 3 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

5. Physical Therapists and Physical Therapy Assistants hold a current North Carolina license to provide therapy services. Yes__ No__
(Page 3 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

6. If appropriate, a licensed therapy assistant is supervised by a licensed therapist. Yes__ No__
(Page 3 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

7. Occupational Therapists and Occupational Therapy Assistants hold a current license to provided therapy services. Yes__ No__
(Page 3 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

8. Speech Therapists hold a current

North Carolina license as defined in the Licensure Act for Speech and Language Pathologists and Audiologists. Yes__ No__
(Page 4 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

9. Medical Social Services are provided in the client's home by a master's degree Social Worker or by a Medical Social Worker Assistant under the supervision of a master's degree Social Worker. Yes__ No__
(Page 4 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

10. Nutrition Care Services are provided by a Dietitian/Nutritionist with a current NC license. Yes__ No__
Page 4 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

11. Skilled services provided support the client's Plan of Care. Yes__ No__
(Page 5 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

12. Individuals provided with Home Health Services are:

a. 60 years of age or older; and Yes__ No__
b. in need of skilled medical care. Yes__ No__
(Page 5 - Home Health Services Standard)

Documentation verifying compliance: _____

_____

Comments: _____

_____

_____

13. Provisions of Home Health Services include:

a. Home Health Services provided complement one another and support the plan of care. Yes__ No__

b. Each client contact is recorded in the client's record. Yes__ No__

c. An assessment of each client is made upon referral. Yes__ No__

d. The Plan of Care is authorized by a physician. Yes__ No__

e. Client reassessments are provided according to the policies and procedures of the home care agency. Yes__ No__

f. Reviewing the Plan of Care is done according to the agency's policies and procedures. Yes__ No__

g. There are policies and procedures regarding the notification of the client's physician when the client's medical condition warrants changes in the Plan of Care. Yes__ No__

h. Drugs and treatments are administered only as directed by the physician responsible for the client's medical care. Yes__ No__

i. Written and/or verbal medical orders are signed by the physician responsible for client's medical care within two weeks. Yes__ No__

j. The Registered Nurse records the date and time of all verbal orders provided by the physician responsible for the client's medical care. Yes__ No__

k. Verbal orders for allied health services other than nursing are given to either a licensed nurse or the appropriate health professional, recorded and signed by the person receiving the orders and countersigned by the physician responsible for the client's medical care within two weeks. Yes__ No__

l. All medications are reviewed with

the client. Yes__ No__

m. A qualified individual such as a physician or public health nurse is available at all times during operating hours. Yes__ No__

(Page 5-6 Home Health Services Standard)

Documentation verifying compliance: _____

_____

Comments: _____

_____

_____

14. Staff qualifications are documented in the personnel records. Yes__ No__

(Page 6 - Home Health Services Standard)

Documentation verifying compliance include:

a. copy of current license. Yes__ No__

b. performance evaluations. Yes__ No__

c. required health examinations. Yes__ No__

_____

Comments: _____

_____

_____

15. Skilled nursing and other therapeutic services are provided under the supervision and direction of a physician or a registered nurse. Yes__ No__

(Page 6 - Home Health Services Standard)

Documentation verifying compliance: _____

_____

Comments: _____

_____

_____

16. A record is kept for each client. Yes__ No__

(Page 6 - Home Health Services Standard)

Documentation verifying compliance: _____

_____

Comments: _____

_____

_____

17. Client records are maintained for at least five years from the date of most recent discharge. Yes__ No__

(Page 7 - Home Health Services Standard)

Documentation verifying compliance: _____

_____

Comments: _____

_____
_____

18. Community service providers offering Home Health services are licensed by the Division of Facility Services in accordance with the North Carolina Home Care Agency Licensure Act (G.S. 131E-142). Yes__ No__
(Page 7 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

19. An update of client registration information is conducted during regularly scheduled service reassessments. Yes__ No__
(Page 8 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

SUMMARY OF CLIENT RECORD REVIEW

For the client record review section, pull a random sample of 5-10% of the active client files, or not less than 10. Use the attached questions to review each client file. You will need to make a copy of the attached questions for each of the client files reviewed. After reviewing the client files, complete the questions listed below to summarize client record information.

Of the _____ (number) of client files reviewed,

1. _____ (number) had a completed assessment/reassessment;
2. _____ (number) had a physician authorized Plan of Care;
3. _____ (number) had physician's orders for pharmaceuticals and medical treatments;
4. _____ (number) had medical orders signed by the physician within two weeks;
5. _____ (number) had a copy of the Client's Bill of Rights and documentation that the client received a copy of his rights;
6. _____ (number) had documentation of identification data;
7. _____ (number) had name of physician responsible for client's care;
8. _____ (number) had names of family members, etc.;
9. _____ (number) had a copy of a signed "Advanced Directive" (if applicable);
10. _____ (number) had client's diagnosis;

11. _____ (number) had record of services provided with entries dated and signed by the individual providing each service;
12. _____ (number) client files contained a completed Service Cost-Sharing form;
13. Out of _____ (number) clients that needed an annual update of the Service Cost-Sharing form, _____ (number) clients had the Service Cost-Sharing information reviewed with them.

General Comments: _____
_____
_____
_____
_____

UNIT VERIFICATION

Verified source documentation exists that unit(s) reported, and for which reimbursement has been received, were in fact received by the specified person on the date(s) indicated on the Unit of Service Report-DAAS ZG 901, 902, 903 or comparable document.

Yes__ No__

SOURCE DOCUMENTATION for **HOME HEALTH SERVICES** is the _____ _____, located in _____.

If the DAAS ZG 901, 902, 903 or a comparable document, contains 10 or fewer clients reported as receiving a unit(s), sample all persons and all units. If 11 or more persons are reported, sample 10% of the persons, or no less than 10, and **all units** reported for each person in the sample.

Attach (as part of work papers) Unit of Service Report or comparable document used to sample clients and units. **IDENTIFY ON THIS FORM** the names of the persons sampled and the sampled date(s) on which units were reported as being provided.

Number of UNITS found unverifiable _____.

This represents _____% of the total units reported for the month of _____, 200__.

Identify by client the date(s) on which a unit(s) could not be verified:

CLIENT NAME	**DATE(S)**	**UNVERIFIED UNIT(S)**

_____
_____
_____
_____
_____
_____
_____

{ copy and give to provider if Unverifiable Units are found }

****

_____ _____
Signature of AAA Administrator/DAAS Staff Date

NORTH CAROLINA DIVISION OF AGING
and
_____ AREA AGENCY ON AGING

MONITORING TOOL FOR HOME HEALTH SERVICES

Community Service Provider _____
Review Date: _____ State Fiscal Year _____
Interviewer: _____
Client Name: _____

****

CLIENT RECORD REVIEW

1. Documentation in each client record includes:

a.	identification data.	Yes__	No__
b.	source of referral.	Yes__	No__
c.	name of physician(s) responsible for client's care.	Yes__	No__
d.	admission and discharge dates from a hospital or other institutions when applicable.	Yes__	No__
e.	assessment of home environment.	Yes__	No__
f.	names of family members, next of kin and/or legal guardian.	Yes__	No__
g.	copy of the Client's Bill of Rights and documentation showing that each client received a copy of his rights.	Yes__	No__
h.	a copy of a signed "Advanced Directive" if applicable.	Yes__	No__

(Page 6 & 7 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____

_____
_____

2. Documentation of service data in each client's record includes:

a. client's diagnosis. Yes__ No__
b. Physician's orders for pharmaceuticals and medical treatments. Yes__ No__

c. initial assessment by appropriate professionals. Yes__ No__

d. a record of services provided with entries dated and signed by the individual providing each service. Yes__ No__
e. identification of problems, the establishment of goals and proposed interventions. Yes__ No__
f. discharge/termination summary. Yes__ No__
g. evidence of coordination of services. Yes__ No__

(Page 7 - Home Health Services Standard)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

3. A copy of a completed Services Cost-Sharing form which addresses the purpose of Service Cost-Sharing, the total cost of the service, the agency's procedures for requesting Service Cost-Sharing, and a statement indicating that services will not be terminated for failure to contribute is contained in the service recipient's file. Yes__ No__

(Page 116 - NC Home and Community Care Block Grant Procedures Manual for Community Service Providers)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

4. A copy of updated Service Cost-Sharing forms exist in the client's file indicating that the following information was reviewed with each service recipient on an annual basis:

a) the purpose of Service Cost-Sharing; Yes__ No__

b) the agency's procedures for requesting Service Cost-Sharing; Yes__ No__

c) that services will not be terminated for failure to share in the cost of the services received; and Yes__ No__

d) the total cost of the service. Yes__ No__

(Page 113 - Home and Community Care Block Grant Procedures Manual for Community Service Providers)

Documentation verifying compliance: _____
_____

Comments: _____
_____
_____

Additional Comments: _____
_____
_____
_____
_____